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MACRO-ECONOMIC POLICIES AND THE HEALTH SECTOR: PAST EXPERIENCES AND FUTURE ACTIONS

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ABSTRACT

The paper presents an analysis of the impacts of macroeconomic policies on the public health sector in Zimbabwe from 1980 to 1998. The presentation categorizes the review period into two: (1) 1980 - 1990, a period characterised by macroeconomic policies which were supporting the health sector to expand services so that health can be accessible to all, and (2) 1991- 1998, a period where economic reforms have been implemented to achieve a more market-oriented economy. A conceptual framework and empirical evidence of the impact of macroeconomic policies on the public health sector are presented. Findings indicate that tremendous gains in health were achieved in the 1980 - 1990 period with all the major health indicators indicating spectacular improvements. While on the other hand, the 1991- 1998 period was characterised by cut backs in the health budget, cost recovery measures, and declines in real incomes of the potential health users resulting in increasing poverty, which have resulted in poor performance of the health sector with some health indicators declining to below 1980 levels. However caution needs to be exercised when interpreting the poor performance of health indicators because the HIV/AIDS epidemic has placed additional stress on the health sector and one can not easily separate the macroeconomic impacts from the HIV/AIDS impacts. Drawing from the presented review on macroeconomic policies and the health sector in Zimbabwe, experiences from other countries, basic projections of the HIV/AIDS epidemic, lessons are outlined that can enable health to be more securely embedded in future macroeconomic policies.

1.0. Introduction

Zimbabwe's health sector has experienced major changes resulting from political and economic changes since 1890 when it was colonized by the European settlers. The governance prior to independence in 1980 pursued a health policy which focused exclusively on the sustained servicing of the urban areas with the majority of the rural population having limited access to minimal health facilities. As a result the health sector inherited at independence was dualistic in character where the urban rich were well serviced but with the majority of the rural population poorly serviced. After independence, the new Government set out to redress the marked inequalities in the health delivery system. Having noted that health is a necessary and primary condition for development, the government embarked on a health policy aimed at equitable delivery of health service to the whole population. Macroeconomic policies were focussed at re-directing resources towards those areas which were neglected or given low priority which included the urban poor and the rural population. This resulted in substantial progress in the health sector with health indicators such as infant mortality rate, maternal mortality, immunization coverage indicating substantial gains.

The increased demand resulting from increased fiscal spending, including exceptionally good rains two years after independence resulted in major economic growth in the early years after independence. However in the late 1980s, the country experienced economic difficulties; characterized by declining investment, low growth rates, weak export performance, increasing debt burden and increasing unemployment. Rapidly growing domestic demand caused the foreign exchange shortages to worsen. Private investment failed to materialize and bottlenecks in the economy led to sluggish growth. The government realized the problems resulting from the macro-economic policies it was pursuing and it was in this context that in 1990, the government

began to implement a structural adjustment program. The economic structural adjustment program (ESAP), resulted in notable decreases in resources for health, erosion of real incomes of the population because of retrenchments, increased poverty and other adverse impacts on the social status of individuals. There is need therefore, to critically scrutinize the impact of these macroeconomic policies on sustainable health delivery. Macroeconomic policies strongly affect the health sector because they determine prices and opportunity costs of the macro resources (labor, capital and foreign exchange) thus affecting the health sector's ability to supply health services and the patients' ability to demand the health service and their impact will extend far beyond the expiration of the program. The degree to which the health sector responds to the changed policy environment is a critical variable in the macroeconomic reform process since good health is a crucial part of well-being which is essential for successful development. The problem is how to restructure the macroeconomy in such a way as to achieve the desired objectives without making the health sector worse off. During a macro-economic reform period this is a challenging mission for all policy-makers. Some authors already view some macroeconomic policies such as those coming under ESAP to be "a clear shift of resources from priority areas of human development (health and education), to the commercial and industrial sectors" Renfew, 1992. But is this true?

The general objective of this paper is to analyse the impacts of macroeconomic policies on the public health sector in Zimbabwe since 1980. Specific objectives include:

- to determine the impact of cut backs in the health budget as a result of fiscal policy aimed at cutting back the overall budget deficit,
- determine the impact of the decline in real incomes of the potential health users and the cost recovery measures implemented under the economic reforms,
- determine how the HIV/AIDS epidemic has placed additional pressure on the health sector and what it means for Zimbabwe's future health requirements
- review the social safety net and suggest areas of improvement
- draw major policy implications for future planning

The paper tries to link changes in macroeconomic policies with changes in the health sector. However determining the causal links is difficult not only because of limitation of data, but also because the health sector is currently experiencing stress from the AIDS epidemic and severe droughts experienced in some of the years under the review period. First, a review of Zimbabwe's macroeconomic policies from 1980 to 1998 is presented with the conceptual framework of the impact of macroeconomic policies on the public health sector presented thereafter. Details on empirical evidence experienced by Zimbabwe's health sector under the different sets of macroeconomic policies is presented next. A review of how the HIV/AIDS epidemic has placed additional pressure on the health sector and what it means for Zimbabwe's future health requirements is presented next followed by a review of the social safety net and suggestions for improvement. The major policy implications for future planning are presented last with a short conclusion.

2.0. Zimbabwe's Macroeconomic policies

2.1. 1980 to 1990 Period

The economy inherited at independence in 1980 was characterised by highly skewed resource endowments with whites who constituted only 3 percent of the population owning more than 66 percent of the income, 42 percent of the agricultural land, and with all social and economic services (health, education, utilities, communications, transport etc.) biased to cater for their needs. Because of the observed socio-economic inequalities, the new government in 1980 decided to pursue a policy of growth with equity with social services singled out as of major priority in the government's development plans. Zimbabwe's economy was highly controlled and regulated. All three macro resources, (labor, foreign exchange and capital) were subject to some form of direct government control. The state owned and controlled the following enterprises: utilities, communications, transport, agricultural, mining. Macroeconomic policies were inward looking and heavily protected and subsidized local industries.

After independence the government continued with the existing policy of rationing and administering foreign exchange allocations, controlling input and output prices throughout the economy. The government expanded health and education sectors in an attempt to make them available to all. The government also expanded the civil service, increased salaries and minimum wages, incurred large defense expenses, expanded agricultural marketing and transport infrastructure to rural areas in the 1980s. While doing this, the government kept an average annual growth rate of between 2.9 and 4% per year, while the population grew by an average of 3% per year. There was just a modest growth in GDP per head as shown in table 1 which presents the major macroeconomic indicators from 1980 to 1996. To pay for the social programs, government had to borrow money and the national debt grew, but the borrowing was well managed so that the burden of repayment began to decrease after 1987 (MacGarry sj, 1993). The government's annual budget deficit remained large, with salaries accounting for the biggest portion of the deficit in 1989.

However in the late 1980s, the country experienced economic difficulties; declining investment, low GDP growth rates, weak export performance, foreign exchange shortages, increasing fiscal deficit and increasing unemployment (see table 1 and 2). To create self-sustaining growth that was required to dramatically improve the standard of living of its population, reduce unemployment, cut large budget deficits, alleviate foreign exchange shortages and the debt burden, the government of Zimbabwe decided to implement a structural adjustment program (ESAP) from October 1990.

2.2. Macroeconomic Adjustment In Zimbabwe: 1990 to present

Zimbabwe's macroeconomic adjustment program include policies aimed at reducing aggregate demand (such as cuts in government spending, restrictive monetary policy, devaluation) and those aimed at increasing aggregate supply (such as deregulation, user charges for public services).

Table 1. Zimbabwe Key Macroeconomic Indicators

	1980	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996
Population (million)	7.01	8.89	9.18	9.47	9.75	10.02	10.28	10.54	10.78	11.01	11.21
GDP US$ million (1987b)	4,417	5,380	5,876	6,247	6,161	6,504	5,973	6,121	6,849	6,375	6,846
GDP growth % annual change	15.0	-1.4	9.2	6.3	-1.4	5.6	-8.2	2.5	6.0	-1.8	7.4
GNP per capita US$, Atlas method	760	590	690	720	710	680	570	540	540	540	620
Government expenditure as percentage of GDP	26.6	28.6	23.7	23.5	23.6	20.4	21.0	20.1	18.5	19.2	19.1
Gross Domestic Investment as percentage of GDP	22.7	17.2	21.8	18.9	23.2	25.0	25.5	21.2	20.0	17.5	17.9
Fiscal Deficit as percentage of GDP	10.3	-9.7	-8.5	-8.8	-7.3	-5.4	-6.2	-4.8	-5.7	-8.3	-7.6
CPI (1990=100)	66.7	74.5	79.4	87.4	100	123.3	175.2	223.6	273.4	335.1	406.9
% change in CPI Inflation	10.25	11.66	6.67	9.98	14.45	23.3	42.09	27.63	22.27	22.57	21.43
Official Exchange rate (Nominal, Z$/ US $)2	0.6	1.7	1.8	2.1	2.5	3.6	5.1	6.5	8.2	9.2	10.8
Real Effective exchange rate index (1190=100)		126.2	117.4	112.7	100	84.0	76.5	79.7	74.2	78.3	84.3
Merchandise exports, fob Millions US$	281	1,455	1,668	1,692	1,753	1,785	1,530	1,610	1,947	2,216	2,500
Merchandise imports, fob Millions US$	308	1,073	1,166	1,323	1,512	1,700	1,781	1,512	1,778	2,128	2,213
Current account balance(excl.net capital grants) Millions US$	-444	-2	51	-78	-258	-547	-837	-311	-318	-369	-133
Total External Debt Millions US$	786	2,626	2,853	2,668	2,791	3,247	3,436	4,006	4,210	4,411	4,885
Total External Debt service payments Millions US$	50	455	513	511	406	422	413	554	587	580	615

Source: World Bank, African Development Indicators 1997.

The main features of Zimbabwe's (1991-1995) structural adjustment program included the following policy measures[1]: (1) Fiscal policy reforms aimed at reducing the budget deficit mainly by cutting down on recurrent expenditure, public enterprise deficits and rationalization of public employment. Measures implemented included cutting down civil service employees, replacing administered prices with market-determined prices for public enterprises and commercializing the activities of some of the agricultural marketing boards (2) Monetary policy and financial sector reforms which were aimed at restraining inflation particularly arising from growth in money supply, promoting savings, reducing capital flight and achieving a more flexible and market oriented money market, (3) trade liberalization to reduce price distortions, completely abandon import controls and liberalize trade and phasing out of the controlled system of foreign exchange allocation and replacing it by the tariff based system (4) exchange rate depreciation to improve the competitiveness of the country's exports through a series of exchange rate devaluations to improve the competitiveness of Zimbabwe's exports, and (5) economic deregulation to allow market forces to operate, hence improve market efficiency in the areas of investment appraisals, pricing, marketing as well as wages. Economic deregulation was aimed at reducing and then entirely eliminating the financial deficits of the marketing boards, increasing the efficiency of the marketing boards, commercializing the operations of the agricultural marketing boards so that the boards operate in competition alongside other marketing channels,

[1]Government of Zimbabwe, 1991, Zimbabwe: A Framework For Economic Reform (1991-1995)

and increasing the participation of private traders in agricultural marketing with the hope of replacing administered prices by market led prices in a competitive environment.

Zimbabwe's markets have dramatically opened up since 1991. ESAP was successful in liberalizing the trade sector, removing foreign trade and foreign currency restrictions. Almost all agricultural commodities have been decontrolled and deregulated. For the labor market, direct government intervention has already been replaced by collective bargaining. However most of the government fiscal targets were not met, the main target of ESAP was to reduce central government deficit from 10% of GDP to 5% by fiscal year 1994/95. Throughout the ESAP period budget deficits exceeded targets, and the target of a fiscal deficit of 5% of GDP by the end of fiscal year 1994/95 was missed by a large margin, the out-turn was 13.5% of GDP (Government of Zimbabwe, 1998). The target of increasing GDP to an annual growth rate of 5%, was not met, instead an annual rate of 0,5% was achieved over the reform program. Total savings targeted to grow from 19.5% of GDP in 1990 to 24% in 1995 only rose to an average of 20.8% over the period. Inflation targeted to decline from 25% in 1990 to 9% in 1995, remained at levels over 20% for most of the ESAP period because of the increasing government debt primarily financed on the local market and overall GNP per capita declined when compared to the 1980s as shown in table 2. The progress of government's efforts to reduce spending under ESAP was also slowed down by the drought in 1992, which required heavy imports of corn, (the principal food) and drought relief in the hard hit areas.

Table 2. Average Annual Percentage growth in Zimbabwe's Key Macroeconomic Indicators

	1975-84	1985-89	1990-1996
Population (million)	3.1	3.3	2.5
GDP US$ million (1987b)	2.9	3.9	1.0
GDP growth % annual change	2.9	3.9	1.0
GNP per capita US$, Atlas method	694	642	600
Government expenditure as percentage of GDP	21.6	25.8	20.3
Gross Domestic Investment as percentage of GDP	20.2	20.7	21.5
Fiscal Deficit as percentage of GDP	11.2	-8.7	-6.5
CPI (1987=100)	11.9	11.2	26.3
Official Exchange rate (Nominal, Z$/ US $)2	0.8	1.8	6.4
Real Effective exchange rate index (1190=100)	Na	126.2	82.4
Merchandise exports, fob Millions US$	0	9.3	5.1
Merchandise imports, fob Millions US$	1.4	6.5	6.5
Current account balance(excl.net capital grants) Millions US$	-353	-46	-396
Total External Debt Millions US$	982	2,671	4,033
Total External Debt service payments Millions US$	107	456	529

Source: World Bank, African Development Indicators 1997.

Government recently embarked on a continuation of the macroeconomic reforms started under ESAP, this time the programme is referred to as Zimbabwe Programme for Economic and Social Transformation (ZIMPREST). In addition to continuation of the market orientation, ZIMPREST objectives are to mobilize savings and investment and to use these efficiently to generate economic growth, employment creation, foster entrepreneurial development and economic empowerment, thereby making possible sustainable poverty alleviation (Government of Zimbabwe, 1997).

These objectives are to be achieved by; (1) reducing government budget deficit, (2) manage expenditure more efficiently, including decentralization of financial responsibility to rural district councils, (3) Restoring government revenue through a reform of the tax policy and administration, (4) Restructuring government for service delivery , (5) Public enterprise reform, (6) Investing in human resources development and ,(7) Providing a safety net for the disadvantaged.

ZIMPREST minimum targets:
Minimum GDP growth of 6% per annum
Per capita income growth of 3.4% and consumption growth of 4.45 per annum.
Reduction in budget deficit from 10% to under 5% of GDP by year 2000
Reduction in inflation from over 20% to a single digit level by year 2000
Sustained improvement in savings and investment performance ie. An investment level of at least 23% of GDP
Continuous growth in exports of at least 9% per annum in US$ terms
Maximization of employment growth: 42 200 new jobs per annum in the formal sector arising from active measures in indigenisation, small-scale enterprise development.

In the health sector, the main priorities of ZIMPREST are:

- increasing the health budget from the average allocation of 2% of GDP during ESAP to at least .5% of GDP during ZIMPREST
- rationalizing the investment programme and ensuring that operating costs of all new facilities can be met before they are constructed
- expanding the role of non-state actors and local authorities in the provision of health care services that they are competent to manage, incorporating a clear system of transferring resources,
- implementing new policies on cost recovery and fee retention to create better incentives for use and management of health services and facilities,
- stepping up programmes on health education, reproductive health and disease prevention, targeting in particular AIDS, TB and malaria.

In concluding this section, Zimbabwe's economy was highly controlled and regulated in the 1980s. All three macro resources, (labor, foreign exchange and capital) were subject to some form of direct government control. This severely crippled investment in the productive sectors of the economy thus leading to low growth. In 1990, the government embarked on ESAP a program aimed at stimulating investment, reducing the budget deficit and removing impediments to growth. Major steps have been undertaken in removing price controls, liberalizing trade and deregulating the markets. However some of the macroeconomic policies implemented to achieve economic reform objectives involve cutting back the health budget, elimination of subsidies, cost recovery, retrenchments and devaluation, policies which are likely to result in direct and indirect impacts on the health sector, a topic which is explored in the next section.

3.0. The impact of Macroeconomic Policies on Public Health Sector: The Conceptual Framework

It is important to identify and analyse the links between macro-economic policies and the health sector since these links are the points of transmission of changes in macro-economic policies to the health sector. Figure 1 summarizes the intended effects of some macroeconomic policies and their impacts on the public health sector.

Figure 1, ESAP: Its aims, impacts on the public health sector

Macro-economic policy	Intended effect	Actual effect	Comment on impact on health sector
Trade Policy currency devaluation	encourage exports	high costs of imported inputs	high costs of imported important equipment and drugs
Tight Fiscal Policy cut government spending	reduce the budget deficit	▸ reduced spending on health sector ▸ cost recovery on health services ▸ retrenchments	▸ cut back in provision of essential health services ▸ cost recovery a burden to users ▸ drop in real incomes of average people
Deregulation of prices, goods and services Decrease in food subsidies	Improve efficiency	increase in prices of basic consumer products	purchasing power of low and middle income groups collapse

The impacts of macro-economic reforms on the health sector presented in figure 1 can be categorized into two; (a) those directly affecting the operating environment for the health sector by affecting the supply of health services (can be referred to as supply-side effects) and (b) those indirectly affecting the health sector by affecting the household characteristics and its ability to demand health services (demand side effects) (see figure 2).

3.1. Supply-side effects

Macro-economic factors affect the health sector directly by affecting the supply of health services, manifested mainly through government cutbacks in expenditure, cost recovery efforts and devaluation which causes very high costs of importing medical drugs and equipment. Fiscal effects: Structural adjustment programs call for great reductions in fiscal spending which may translate to reduced funding for the health sector capital development and operating costs. Fiscal adjustment also call for cut back of the public sector wage bill. Various mechanisms may be used, such as hiring freezes, early retirement programs, reduction in the use of nonpermanent employees, and wage restraint. Some of these measures may adversely affect the health sector institutions by reducing incentives to work. In extreme cases the institutions may lose more talented and experienced individuals.

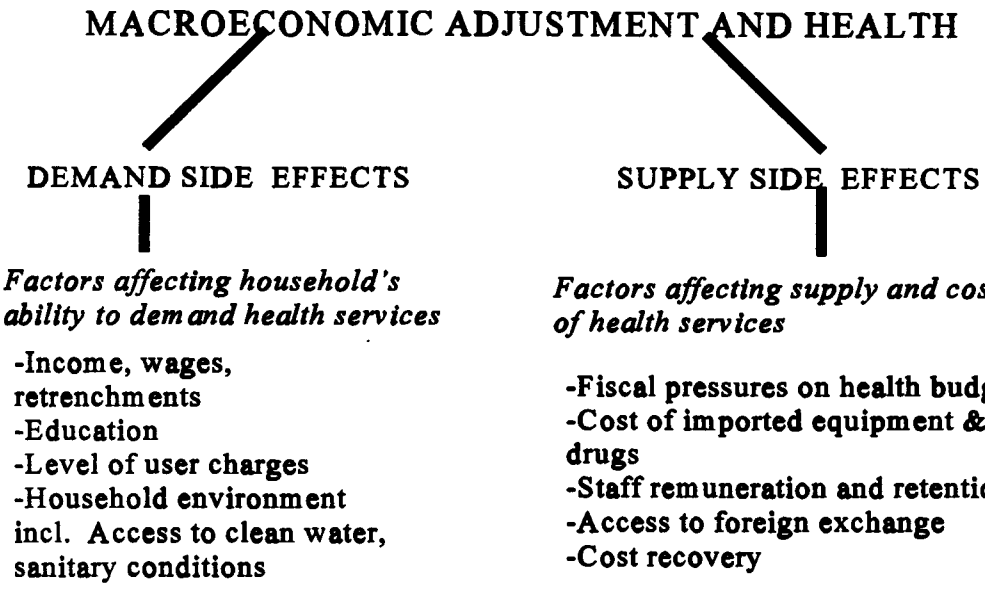


Fig. 2. Factors that influence demand and supply of health services under macro-economic reforms

An important question for the health sector is the extent to which it is affected by the cuts and how the cuts should be distributed between current and capital expenditures. If cuts are in essential services such as primary health care, then this can have severe implications on national health status.

Exchange rate devaluation may make it more expensive to obtain imported equipment and overseas training. This implies that health institutions are limited to import scientific equipment and drugs required for health services.

The overall impact of the supply side effects may result in a decrease in the supply of health services which can be manifested by a backward shift in the supply curve or a movement along the supply curve illustrated in figure 3.

3.2. Demand side effects

Structural adjustment programs may alter the income status of health service users. Health can be viewed as a result of a production function in which the output, health, is determined by different controllable and noncontrollable factors (Behrman, 1993). Theory suggests that the health status of an individual household member (H_i) depends on the individual's social, behavioural, genetic, cultural, political, climatic and geographic circumstances which determine the quantity and nutritional levels of food items consumed (Fi), income level (Yi), personal variables (Pi) such as education and personal hygiene, and exogenous factors such as access to clean water, sanitary conditions, access to and quality of health services (K_i) etc. The health production function can be expressed as:-

$H_i = f(F_i, Yi, P_i, K_i)$

The single most important factor is income which determines the level of consumption of the food and nonfood items (Renfew, 1992). Very poor social circumstances characterised by poverty leads to poor nutrition, poor hygiene, poor housing, lack of education, lack of sanitation, more deaths in childhood, more maternal ill-health resulting in poorer care for the family. As incomes improves and consumption of basic goods improve, so does health, but as incomes and the social circumstances deteriorate, so does health. As the costs of basic food, transport, health, education and other commodities rise because of deregulation and cost recovery, the purchasing power of individuals deteriorate and this has negative impacts on their nutrition and health status in general. Macroeconomic policies that affect incomes of the general population such as employment availability, retrenchments, wages and inflation thus indirectly affect the health of individuals. Such policies that result in overall reduction in income results in reduced consumption of health services such as drugs, medical fee etc, have an overall effect of reducing the demand for health services as depicted in figure 3 (all else constant).

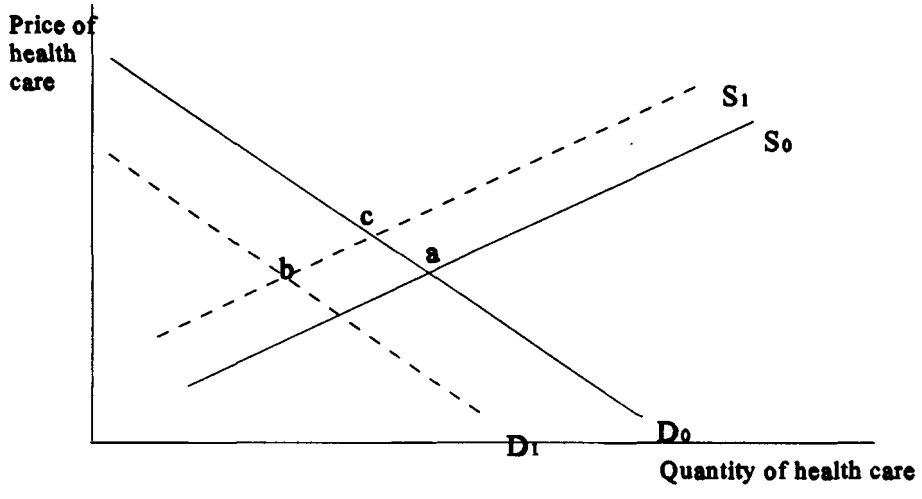


Fig. 3. Demand and Supply of Health Services under macro-economic reforms

Devaluation improves the terms of trade for agriculture as a whole and changes the relative prices within the sector in favor of goods and services that are traded. This will encourage increased production of tradable crops such as cotton, tobacco and horticulture. However this may not be beneficial to all farmer types in all agroecological regions. Small farmers growing primarily non-tradables will be worse off than other smallholder farmers and large scale commercial farmers who produce for export, since the profitability of tradables is higher relative to non-tradables.

In concluding this section, the general rise in prices of basic commodities associated with deregulation of goods markets, elimination of food subsidies, and devaluation all affect the purchasing power of households. While households and individuals with higher incomes may cope with temporary or even longer-term short-falls without experiencing serious effects on their ability to meet basic needs, such as food, shelter, nutrition and health, the poor households

usually do not have the resources to unlink decreasing incomes and the degree to which basic needs are met (Pinstrup-Andersen, 1993). Their health is therefore very vulnerable to macro-economic policies which erode incomes and cut backs public health expenditure. It is important to identify supportive policies and programmes that ensures that the health of the poor does not deteriorate. If health supply services are also diminishing because of cutbacks in government expenditure, it means that overall there will be less health services available to the public. The next section looks at the empirical evidence from Zimbabwe's health sector.

4.0. Evidence from Zimbabwe: Health Sector Performance From 1980 to 1998

Health services in Zimbabwe are provided by (1) Government through: rural health centers (primary level), District Hospitals (secondary level), Provincial hospitals (secondary level), and Central hospitals (quartenary level), (2) Municipalities and rural district councils (primary level clinics and maternity hospitals), (3) Church mission hospitals and clinics, (4) the private sector (general practitioners, clinics, hospitals and specialist practices), and (5) employers such as in mining and industry (see annex 1, for details on the number of health facilities by type of institution). Government, through the Ministry of Health and Child Welfare, plays both a funding and supervisory roles to all health facilities operated by municipalities, missions, and rural district councils.

At independence health services were highly developed mainly for the rich urban minority, while under serving the very poor in the rural areas. In 1977-78, Harare group of hospitals serving only 8.7% of the population took 29.7% of the government's health budget (1993). While rural health services depended on the mission hospitals who provided 2/3 of the rural beds. Emphasis was also on curative facilities, insufficient attention was given to preventive and promotive services for health development (World Bank, 1981). In 1977/8, out of a government vote of Z$40.2 million, 86.7% was spent on curative services and only 9% on preventive services (Mac Gary sj). At 1979, the Ministry of Health facilities mostly serviced inpatients cost who cost substantially higher than outpatients. Local authorities served roughly equal number of people as outpatients. Mission clinics some partially funded by Ministry of Health via grants were responsible for 60% of 2600 out of 3560 hospital beds in the rural areas. In 1980, the average national number of persons per hospital bed was 500 persons per bed broken down to 600 persons per bed in the rural areas and 300 persons per bed in the urban areas.

Thus given such an inequitable distribution of health services in the country, the government at independence took major steps to redress these disparities. Following its equity in health growth strategy, the government embarked on expanding primary health care to the rural areas. This involved emphasizing recruitment and training of village health workers who in addition to diagnosing and treating simple common diseases, educated the community on nutrition, hygiene and personal health care. Large numbers of village health workers were trained, many local clinics and district hospitals were built. Health services were brought much closer to the people and, to make them more accessible, no fees were charged from patients earning less than Z$150 per month (a little below the 1980 poverty datum line). The government also had to redress the emphasis which was curative rather than preventive focus of the health system in order to improve its cost effectiveness. About 90% of the diseases in Zimbabwe in 1980 were preventable (World Bank, 1995).

Zimbabwe achieved very dramatic improvements in the health sector from 1980 to 1988. Notable achievements include (see annex 2):

- Expanded primary health care to cover rural areas
- Improved health education and prevention
- Community mobilization
- Infant mortality declined from greater than 90 per thousand to nearly 53/1000
- Child malnutrition (stunting) declined from 30% to less than 20%
- Children fully immunized increased from 25% to 80%

Government expenditures on the health sector

Government expenditures on public health had experienced real increases through out the 1980s as it embarked on expanding primary health care to the rural areas and to the urban poor. However since 1990, real government allocations to the Ministry of Health and Child Welfare has decreased from 6% of total government expenditure to about 4% (see table 3). A similar picture is presented by health expenditures as a percentage of gross domestic product and per capita health expenditures which have decreased throughout the 1990s and have remained consistently below the 1990 level. This has placed severe constraints on the ability of the health sector to offer health services. The government has also been reducing its grants to cities and municipalities for health care.

Table 3. Real Recurrent Health Expenditure, 1980/81 - 1995/96, Ministry of Health and Child Welfare, 1990 prices.

Financial Year	Total Real Health Exp. (Z$millions)	Total Real Health Exp. Per Capita	Health Exp. As a % of GDP	Health Exp. As a % of total Govt. Exp.
1980/81	256.24	35.62	2.0	5.3
1981/82	306.60	41.44	2.2	5.6
1982/83	300.10	39.44	2.1	4.8
1983/84	289.61	36.74	2.2	4.8
1984/85	291.97	35.92	2.3	4.9
1985/86	331.00	39.48	2.5	5.3
1986/87	355.64	41.14	2.8	5.1
1987/88	384.10	43.08	2.8	5.5
1988/89	412.18	44.82	2.6	5.4
1989/90	478.88	50.50	2.8	5.9
1990/91	564.49	57.72	3.0	6.2
1991/92	511.97	50.76	2.5	5.1
1992/93	458.18	44.00	2.4	5.3
1993/94	412.88	38.45	2.2	5.1

Financial Year	Total Real Health Exp. (Z$millions)	Total Real Health Exp. Per Capita	Health Exp. As a % of GDP	Health Exp. As a % of total Govt. Exp.
1994/95	424.33	38.31	2.2	4.5
1995/96	409.71	35.86	2.2	4.2

Source: Chandiwana S, Woelk G, Sikosana P et al, 1997.

Investment in health in the 1980s resulted in substantial gains in the health indicators, but the cutbacks the health sector has been experiencing is threatening to reverse the gains. It is important to identify the areas in health that are experiencing cutbacks. If cutbacks are in more basic cost-effective primary health services that are required by the poor, then such cutbacks can have significant effects on the poor. Information on the distribution of health expenditure among the different sectors in MoHCW indicate that at independence, the health services were heavily biased in favor of curing rather than preventing disease, with curative services accounting for more than 89% of total expenditures. Post-independence health sector development managed to improve allocations to preventive services from about 7% in 1980 peaking at 12% in 1994/95, recently the allocation has decreased to about 11% (see table 4). It is important that allocations to preventive services are improved because in order to sustain health improvements which had been achieved since independence.

Table 4. Ministry of Health and Child Welfare Expenditure by sector Million Nominal Z$

Sector	1979/80	1980/81	1981/82	1983/84	1986/87	1990/91	1994/95	1995/96	1997/98[1]
Administration and General	1.71	2.53	3.89	5.19	11.72	15.13	30.80	32.09	185.90
Medical Care Services	45.54	74.91	95.71	114.26	195.59	382.59	1246.80	1160.79	3186.72
Preventive Services	4.52	5.60	7.94	16.33	24.55	59.13	183.60	156.15	427.26
Research	0.54	0.70	0.54	0.81	1.16	2.61	6.00	5.89	18.16
TOTAL	52.31	83.73	108.08	136.59	233.02	459.47	1467.20	1354.92	3818.05
Ministry of Health and Child Welfare Percentage of total Expenditure by sector (%)									
Sector	1979/80	1980/81	1981/82	1983/84	1986/87	1990/91	1994/95	1995/96	1997/98[1]
Administration and General	3.27	3.01	3.60	3.80	5.03	3.29	2.10	2.37	4.87
Medical Care Services	87.05	89.46	88.56	83.65	83.94	83.27	84.98	85.67	83.46
Preventive Services	8.64	6.69	7.35	11.95	10.53	12.87	12.51	11.52	11.19
Research	1.02	0.84	0.50	0.59	0.50	0.57	0.41	0.43	0.48
TOTAL	100	100	100	100	100	100	100	100	100

[1] Estimates.

Source: Central Statistical Office, Statistical Yearbook 1989.

As a result of cutbacks common problems experienced by the public health sector include[2]:

- inadequate laboratory equipment in wards at the top of the referral pyramid system to work
- shortage of operating time due to operation theater equipment breakdown and repairs or

[2] Iliff, 1995.

replacement taking long

- insufficient numbers of appropriately trained medical health personnel such as anesthetists
- difficulties and delays in referral especially from rural areas due to poorly maintained or inadequate number of ambulances
- rural hospitals and clinics without drugs or gloves (in 1995, drug availability for rural health sector was 70%)
- central hospitals without trained staff to manage the country's referral system

The health services expanded services in form of building new clinics and hospitals in the 1980s, expanded existing primary health care facilities including nutrition, immunization programmes, maternal and child health programmes and made them accessible to the rural population. With the cuts in health expenditures being experienced in the 1990s, some of the institutions are now running below capacity and some have closed as evidenced by annex 1, while some expansion projects are lying idle because of lack of funds to complete and run the institutions.

Other active public health providers particularly the city councils and mission hospitals have been receiving lower allocations from government. "As the Harare city council's financial situation continue to deteriorate, the city health department has to seriously address the issue of what services to provide and for which people. Council should become more regulatory and facilitatory than deliver health services because shortage of funds had resulted in the non-payment of accounts and disruption of goods and services. Lack of funding made it impossible to repair malfunctioning equipment at the dental clinics while limited funds were used to cover critical areas such as maternity drugs, children's medications and other hospital drugs. " (Director of Health Services quoted in the Herald of 18 July 1998).

In concluding this section, Zimbabwe made impressive gains and consistent progress in health and nutrition in the 80s resulting in large improvements in health indicators such as infant mortality rate, child immunization coverage, between 1980 and 1988 (see annex 2). However since 1991 health indicators such as infant mortality rate, maternal mortality, adult mortality and child mortality have been on the increase. However care needs to be exercised in interpreting this decline to be from macroeconomic policies only, because of the other stressing factors namely AIDS and drought (the country experienced a major drought in 1992, and another drought in 1995).

Health personnel

Salaries and other aspects of terms and conditions of service need to keep up with inflation and rising expectations if medical staff are to remain in the public sector. The massive depreciation of the domestic currency since the onset of ESAP has led to large decreases in real service salaries and this has been a disincentive for highly qualified and experienced medical staff. Real wages for health personnel fell by about one third (Government of Zimbabwe, 1998). Of the doctors trained at the University of Zimbabwe Medical school, 80% no longer work in the public sector, in-post pharmacists rarely exceeded 70% in the 1990s and the same drain applies to other staff categories such as nurses, laboratory technicians and radiographers. As shown in figure 4,

notable decreases in health personnel particularly doctors, nurses, laboratory technicians and x-ray staff have been experienced since 1983. This has resulted in a worsening of the number of people serviced by one of these medical personnel. As shown in figure 5 the number of people per doctor, per nurse, per laboratory staff and per x-ray staff has increased substantially since 1983 indicating that medical personnel resources are being overstretched.

Fig. 4. Health personnel resources (1983 and 1995)

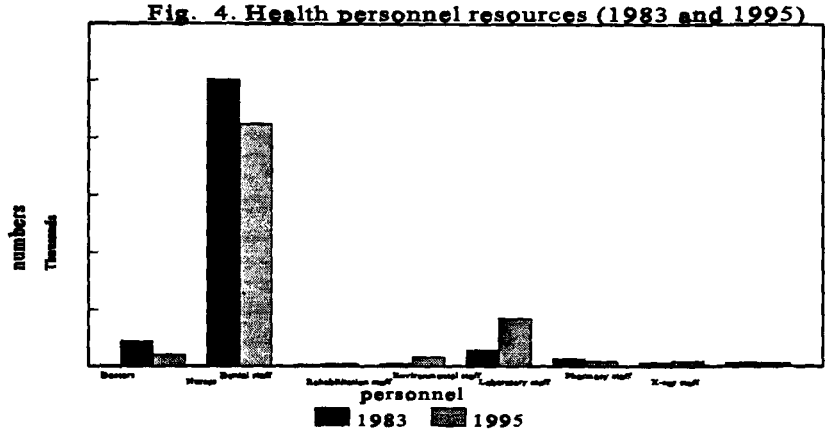
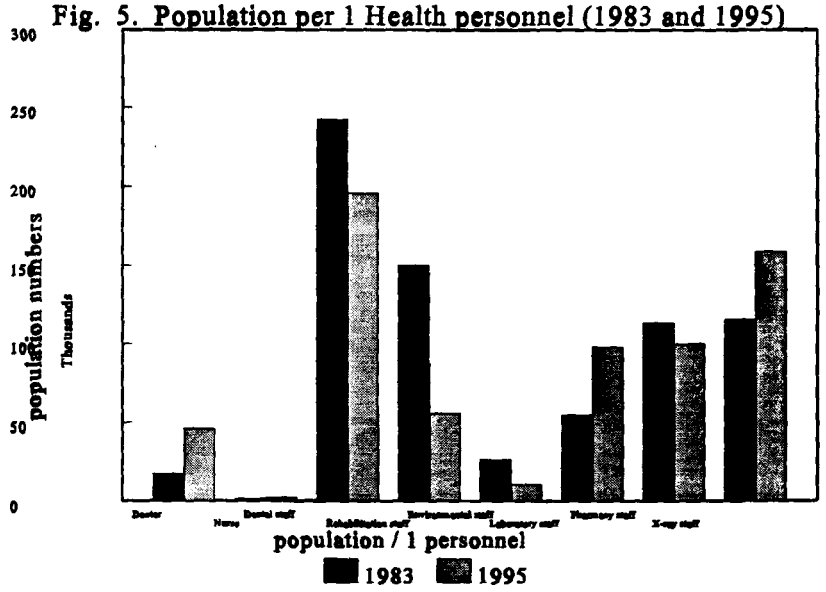


Fig. 5. Population per 1 Health personnel (1983 and 1995)



User fees

User fees have been on the increase since 1991 when they were increased and enforced in line with the requirements of ESAP. The total revenue generated by fees has typically been 2% of total expenditures on public health services (Normand et al, 1996). Zimbabwe's user fee structure is designed to support the referral system, by encouraging patients to seek services at the lower levels of the health system (Chisvo and Munro, 1994). However Normand et al and Chisvo et al reports indicate that the user fee system fails to meet this function as many health users were still consulting secondary level health care without being referred by primary health facilities. Other

problems facing the user fee system include:

- the determination of the user fees, which is not based on the costs of providing the service
- the exemption level, which is not based on any empirical analysis
- all fees collected are not available for direct utilization by MoHCW, creating enforcement problems
- the user fees are so low such that probably they do not cover the costs of administering the system (Illif, 1995)

The Blair Research Institute commissioned a study on The Effects and Impact of Hospital User Charges on Health Care Delivery in Zimbabwe in 1994. Comparing data from before and after the enforcement of user charges the study found out that outpatient attendances at the eight hospitals and one clinic in their study had dropped by 18%, while antenatal attendance had dropped by almost 40%. On the other hand, the inpatient numbers increased by 12%. Their conclusion was that people were cutting down on what they thought were unnecessary services, only to come later with more serious conditions. The higher fees also forced people to go to alternative source of health service such as traditional healers. Similar behaviour was reported in other countries. In Nigeria, the introduction of a SAP was followed by a decrease in antenatal clinic attendance, an increase in neonatal tetanus, an increase in the perinatal mortality rate and an increase in the number of babies delivered at home (Illif, 1995). In Kenya , the introduction of a cost recovery programme resulted in decreased attendances, confusion, even harassment of patients to such an extent that it was discontinued after ten months. Attendance of men at STD clinics dropped to 40% of previous levels and rose again after the abolition of charges (Illif, 1995). This implies that user fees can discourage use of health service and can therefore potentially contribute to the deterioration of national health status.

Impact on incomes, poverty and prices

As pointed out in the conceptual framework, macroeconomic policies affect households and individuals mainly through incomes (availability of employment and wages), access to and affordability of food and health services. Countrywide, ESAP resulted in prices of basic food rising as subsidies were removed, unemployment rose as companies closed due to competition, public sector employment fell due to retrenchments, and real wages in the formal sector have been on the decline since 1990 (see table 5). Annual increase in formal employment has been very small as shown in table 5. Massive retrenchments in the civil service resulted in many people losing their source of regular income. About 94% of the targeted 25% of total civil servants posts were abolished resulting in a drop in the civil service wage bill of 6% from 1991 to 1995.

In agriculture, the largest formal and informal employer, the economic reform program has had a differential impact on the different farmers in Zimbabwe. Whilst the reform program has generated opportunities for the large scale commercial sector, it has created different constraints for the smallholder sector (Government of Zimbabwe, 1995). Macro-economic policy changes, particularly devaluation, has stimulated increased diversification of large scale commercial producers into horticulture, ostrich production and wildlife farming. The country has also witnessed increased production of export oriented crops. However the disturbing fact is that most of this growth is coming from a combination of 50 percent of large scale commercial farmers and

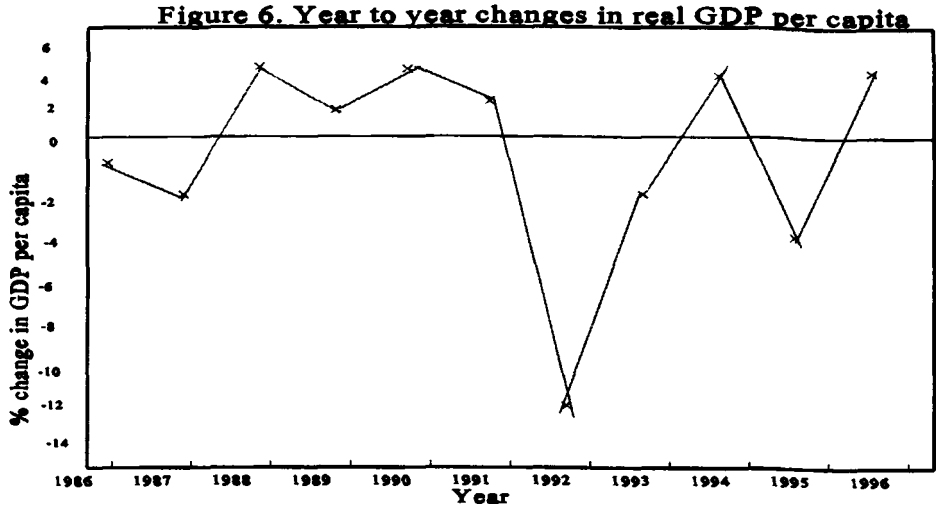
10 percent of smallholder farmers (Government of Zimbabwe, 1995). The growth is also restricted to the high potential areas. This phenomenon is in line with studies by Vudzijena (1992) and Mutangadura (1993) who concluded that farmers in high potential areas where yields and profitability is quite high may benefit from the structural adjustment program more than those in the dry regions. This is because the tradable crops whose prices are likely to increase after a devaluation, can grow viably and are more profitable in high potential areas.

Table 5. Employment and real wages in the formal sector

Year	EMPLOYMENT (000)			CPI	AVERAGE MONTHLY REAL WAGES	
	AGRIC	NON-AGRIC	TOTAL	1990base	AGRIC	NON-AGRIC
1978	341	645	986	24.9	92.42	602.76
1979	335	650	985	27.7	90.38	600.13
1980	327	683	1010	30.5	104.93	642.68
1981	294	743	1037	34.6	152.98	698.52
1982	274	772	1046	40.7	147.48	688.25
1983	264	770	1034	46.5	150.41	672.56
1984	271	765	1036	52.5	142.98	672.96
1985	275	787	1062	58.2	128.82	683.63
1986	275	806	1081	66.7	127.44	706.18
1987	263	820	1083	74.5	164.05	633.14
1988	277	854	1131	79.4	173.78	666.62
1989	285	881	1166	87.4	172.52	672.95
1990	290	877	1167	100	182.87	716.42
1991	304	929	1233	123.3	164.92	627.35
1992	300	936	1236	175.2	97.87	556.82
1993	324	916	1240	223.6	109.23	500.41
1994	329	934	1263	273.4	104.95	481.00
1995	334	906	1240	335.1	88.27	484.65
1996	347	926	1273	406.9	98.65	532.29
1997	349	957	1306	483.6		

Source: CSO Quarterly Digest of Statistics

Figure 6. Year to year changes in real GDP per capita



The onset of ESAP also coincided with one of the country's worst drought in 1992.The economy failed to exhibit growth in the early 1990s, and the separate effects of drought and ESAP are difficult to differentiate. The overall effect was making low income households worse off. The 1995 PASS study shows that 40% of rural Zimbabweans and 29% of all Zimbabweans attribute drought as the main cause of poverty. The increase and enforcement of health fees resulting from ESAP lowered the affordability of such services by the poor. Thus in general the ESAP period has been characterised by lower real per capita incomes due to the general economic decline experienced in the period (see figure 6). Average per capita real incomes have been on the decline particularly since 1990 as shown in figure 6.

As agricultural parastatals commercialized as a result of ESAP most basic food commodities experienced increases in prices since 1990 averaging about 400% for food and 500% for nonfood in nominal terms (see table 6). As part of ESAP health and education fees were increased and enforced, lowering the affordability of these services by the average, low income and poor households. The 1995 Poverty Assessment Study (PAS) found out that 62% of the national population was living below the national total consumption poverty line of Z$2132.33 per person per annum[3] (MPSLSW, 1997).The prevalence of poverty was higher in rural areas than in urban areas (see table 7). Estimates by the World Bank in 1995, using the 1990/91 Income and Expenditure Survey data also indicate poverty to be more prevalent in rural than in urban Zimbabwe as shown in table 7.

[3]Total consumption poverty line gives the income required to purchase a basket of food and non-food (clothing, housing, education, health, transport etc) by an average person per annum.

Table 6 Consumer Council of Zimbabwe Low income urban Earner Monthly Budget for a family of six (father, mother and four children)

Item	Nominal COST Z$			
	January 1991	September 1994	November 1995	September 1997
10kg Roller meal x 6	29.22	60.00	192.00	175.86
2kg White sugar x 5	20.90	33.69	47.00	56.95
2kg Margarine	5.90	16.85	32.00	34.82
250g Tanganda x 2	6.12	110.80	15.00	19.26
500ml Milk daily	20.00	54.00	67.50	123.69
Cooking oil 750ml x 2	6.34	16.94	21.00	28.90
1 loaf bread Daily	29.70	78.00	126.00	148.80
2kg Rice x 3	9.00	18.30	27.00	48.45
Meat and Vegetables	80.00	200.00	295.00	379.62
TOTAL FOOD	**207.18**	**588.58**	**822.00**	**1016.35**
Soft Drinks, Alcohol & Tobacco	25.00	45.00	60.00	100.00
Soap and Detergents	20.00	50.00	80.00	110.00
Rent 3 rooms high density	100.00	300.00	450.00	600.00
Durable Household Goods	50.00	50.00	90.00	100.00
Maintenance and Heating	25.00	100.00	300.00	500.00
Health	50.00	50.00	150.00	250.00
Education	40.00	60.00	330.00	400.00
Clothing and Footwear	60.00	70.00	95.00	220.00
Transport (worker&school children)	100.00	380.00	400.00	600.00
TOTAL NON--FOOD	**470.00**	**1105.00**	**1955.00**	**2880.00**
TOTAL	**677.18**	**1693.58**	**2777.50**	**3896.35**

Source: Consumer Council of Zimbabwe.

Note: The table shows that in nominal terms the average budget share of food was roughly 30% of the total expenditures, which is very close to the CSO food share. The basket is limited only to urban consumers.

Table 7. Poverty prevalence by land use group

	Poverty Assessment Study Estimates for 1995		
Sector	Very poor	Poor	Non Poor
Communal areas	68	13	19
Large scale farming	38	21	49
Small scale and resettlement areas	54	13	32
Urban areas	25	21	54
	World Bank 1990/91 estimates		
	Very poor	Poor	
Communal areas	33	10	
Large scale farming	16	3	
Small scale and resettlement areas	41	14	
Urban areas	10	2	

Source: World Bank, 1995, Poverty Assessment study, 1996.

In concluding this section, direct effects of ESAP on the health sector have been more vivid and have had severe impacts on the amount of financial resources available to the health sector, and on staff remuneration and retention thereby undermining the ability of the health sector to provide adequate health services. On the other hand, macroeconomic policies have had negative impacts on the incomes of the population resulting in a very high percentage (46%) of people living below the national food poverty line. These households are unable to meet basic nutritional needs later alone health services. It is therefore important that macroeconomic policy makers identify and incorporate such differences in their plans. This indicates that policy must take into account this differential impact of macropolicies, in order to yield the greatest possible degree of equitable growth. The cost of ignoring such disparities in the health system can be high and irrecoverable.

5.0. The Impact of the HIV/AIDS epidemic on the health sector

HIV/AIDS has some characteristics that gives it an economic impact that has very important development implications[4]. First the disease has a long incubation period (averaging about 7 years in adults in developing countries) during which labor productivity is lost, eventually leading to death. Second the disease is found in two specific age groups, infants and the adults aged 20 to 45 years (the most productive age). The high morbidity and mortality rates associated with HIV/AIDS thus have far reaching impacts which go beyond the health sector affecting all aspects of the economy.

[4]Ainsworth and Over, 1994, and Lowenson and Whiteside, 1997.

HIV/AIDS impacts the health sector both through the demand and supply sides. Its impacts complicates the impacts of macroeconomic policies. Demand side effects include a rise in the demand for health services from AIDS patients for three types of care[5]: (1) palliative care consisting of treatment of relief of symptoms such as headache, pain, diarrhea, etc (2) prevention and treatment of opportunistic infections associated with AIDS such as tuberculosis and pneumonia: (3) antiretrovial (ARV) treatment which attempts to control HIV infection and slow down the progression to AIDS and AIDS related death. Health services for (1) are least expensive, treatment for (2) is somewhat expensive but because some of the diseases are infectious, it is in the government's interest to treat them regardless of whether an individual's HIV status, and antiretroviral therapy is expensive averaging at Z$18 000 per month (up from Z$6000 per month in 1996) on drugs alone with additional cost for viral load testing averaging Z$2000 per month[6]. These costs make use of ARV prohibitive in developing countries.

Supply side effects include decrease in supply of services through staff absenteeism, mortality, attrition due to stress and burnout, and training and replacement of staff. In some countries high levels of HIV seroprevalence have been recorded among health workers, and some countries report that health personnel leave the profession because of the high risk of exposure to HIV infection.[7] The overall effect depicted in figure 7 would be an increase in the price of health care as demand increases and supply decreases.

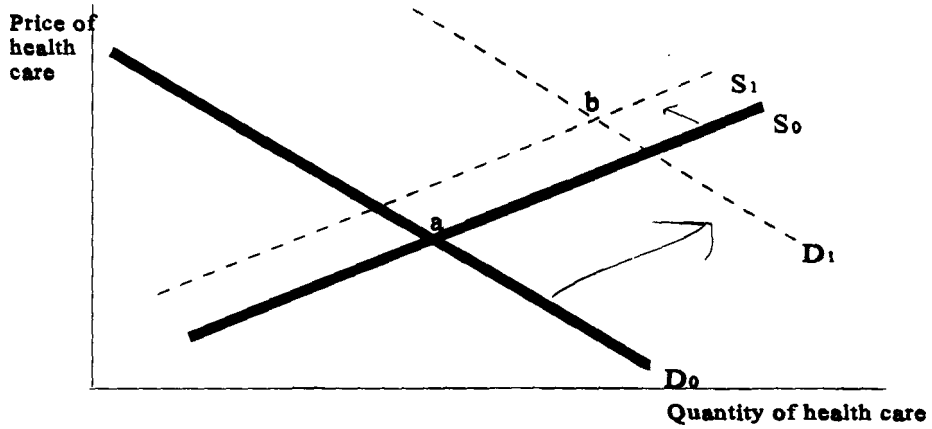


Fig. 7. Demand and Supply of Health Services under constraining factors such as AIDS or drought

When this happens Ainsworth et al argue that overwhelmed public health systems are forced to

[5]Ainsworth and Over, 1997.

[6]Annual costs in the USA for antiretroviral therapy were estimated to be US$19803 by Ainsworth and Over, 1997.

[7]Barnett et al, 1996.

resort to rationing its hospital beds and by so doing turn away genuine non-AIDS related curable cases and national expenditure on health increase as the sector tries to meet increased demand. Evidence from Kenyatta hospital in Nairobi indicate that utilization of the hospital by HIV positive patients increased from 4.3 to 9.6 per day while the utilization by HIV negative patients declined from 18.7 to 15.3 per day (an increase from 19% to 38% of total AIDS cases). In Zimbabwe, the average length of an AIDS patient in hospital is about 37 days and in 1990 an estimated 4.3% of all hospital beds was occupied by AIDS patients (NACP). With the increase in the epidemic, it is estimated that the proportion of beds occupied by AIDS patients will increase to such a level that two in every three beds available would have to go to service an AIDS patient in 2005 (NACP, 1997).

Today Zimbabwe is rated to be one of the Sub-Saharan African countries experiencing the highest HIV/AIDS rates with an estimated 1.5 million of the 11.7 million being HIV positive (UNAIDS, 1998). Since the outbreak of HIV/AIDS in Zimbabwe, the number of reported AIDS cases, STI episodes and new TB cases have been increasing (see table 8). Many cases go unreported, however, and it is estimated that, by the end of 1996, more than 250 000 people in Zimbabwe had developed AIDS (NACP, 1996). HIV has spread throughout the country, and AIDS cases have been reported from every district. The relative ease with which people travel between urban and rural areas may have contributed significantly to the rapid spread of the disease, as well as factors such as high levels of untreated STIs.

Table 8. Zimbabwe Reported AIDS Cases, STI Episodes and New TB cases by Year

Year	Reported AIDS Cases	STI Episodes	New TB cases by year
1986	na	559500	na
1987	119	668422	na
1988	202	971790	6002
1989	1311	1078293	6812
1990	4362	963436	9132
1991	4557	1240596	12198
1992	8180	878366	15237
1993	9174	879307	20125
1994	10647	813698	23959
1995	13356	894885	30831
1996	16149	na	na

Source: Source: HIV, STI, and AIDS Surveillance Zimbabwe, Quarterly Report March 1996. Quarterly Digest of Statistics, December 1997.

In 1997, UNAIDS country data indicated that Zimbabwe's adult HIV rate to be 25%, where adults ages 15-49 accounts for 48% of the total population of 11.6 million. The estimated AIDS deaths was 130 000 in 1997, cumulative deaths at 590 000 in December 1997, and AIDS orphans

were 450 000.

Direct costs of treating palliative and inexpensive opportunistic infections for HIV positive patients were estimated to be US$300 per case per year, in Sub-Saharan Africa[8]. However this varies from country to country depending on the health facilities available. A 1996 study by CIMAS on health claims submitted by 4933 positively identified AIDS cases who died during the year under review indicated an average of Z$7220 per AIDS case, an increase from Z$4928 and Z$3095 of 1995 and 1994 respectively (general practitioner and hospital costs account for the highest proportion of total costs ie. 29 and 21% respectively)[9]. These costs are prohibitive for average and low income households in Zimbabwe, thus the incurred costs have to be met by the public health sector. Basing on the AIDS Impact model (AIM), and CIMAS 1995 health costs per AIDS patient, the NACP projected that AIDS patient care costs will be Z$841million in the year 2000 (NACP, 1997). Using the 1994/95 MoHCW budget, the NACP calculated that by year 2000 about 56% of the entire budget will be required to meet the needs of AIDS patients (note that the figure is based on private sector health costs). However with data limitations this figure can be used as an indicator of the cost burden the AIDS epidemic is likely to place on the health sector in future.

AIDS also affects major demographic indicators such as mortality, life expectancy, whereas total death rates had fallen to 9 per thousand in 1992, it rose to 12.5 in 1997 and will continue to rise in the medium term as those who are currently HIV positive develop AIDS and die. The population growth rate in 1997 was estimated at 2.2% and projections based on the number of HIV cases in the country indicate that the rate will fall to about 1% by 2000 (Jhamba T, 1997). The HIV/AIDS epidemic has resulted in a decrease in the life expectancy which had improved to 62 by 1994, to fall down to 53.4, and 49 in 1996 and 1997 respectively (UNAIDS, 1998). This has pushed back national health welfare to levels even worse than at independence and thus pose as a major threat to reversing all the progress which had been achieved in the health sector since independence (see annex 2).

Government's response against HIV and AIDS in Zimbabwe has been very slow and has generally been taken as a health problem and largely left to the Ministry of Health and Child Welfare (Mombeshora, 1998). The Ministry of Health and Child Welfare in 1987 established the National AIDS Coordination Programme (NACP) to coordinate the involvement of different stakeholders (such as government ministries, the Family Planning Council, the private sector, non-governmental organizations) in the response against HIV/AIDS. The NACP's programmes focus on (1) STI training for nurses, tutors and service providers, (2) awareness and prevention targeting on in and out of school youth, women and at workplace, (3) in collaboration with the Family Planning Council co-ordination of condom distribution to sexually active men and women, (4) coordination of STI, HIV/AIDS counseling and training at national, provincial and district levels, (5) mobilization of resources for HIV testing, and (6) coordination and support of organizations offering home-based care to AIDS patients. The NACP is also developing a

[8]Ainsworth and Over, 1997.
[9]SAfAIDS News, 1997.

national HIV/AIDS policy and a national plan for orphan care.

Although the NACP is still government's main response to HIV/AIDS, government's resource allocation to NACP has been very low accounting for 8.4 of total NACP's expenditure with the rest coming from donors. Given the development impacts that AIDS has at national, sectoral and household levels, there is need to strengthen government's commitment in the fight against the disease. Most importantly to intensify the prevention interventions since prevention is still the most cost-effective response against the epidemic. But also to mobilize resources and go beyond health interventions in helping mitigate the impacts of the epidemic and have the appropriate legislation implemented.

In addition to the direct medical costs of AIDS, huge indirect costs disproportionately fall on households resulting in increased dependency and increased health expenditure. Death of a breadwinner might force a household into impoverishment thereby forcing the household to be susceptible to disease and poor health. Government's long term strategies in particular should address the underlying structural factors which fuel the spread of the epidemic and exacerbates the household impact of the disease such as:

- poverty
- health problems incorporating improved water and health services.
- agricultural constraints including poor access to land, credit, markets, droughts etc. eg. through introduction of irrigation

All formal, government and non-governmental rural development institutions can play a bigger role if they reform their policies and programmes to respond to the needs of the HIV/AIDS affected households. Priority intervention areas center around:

Awareness and Prevention activities such as;

- condom distribution
- targeted AIDS education (peer education, workplace education, youth, women)
- voluntary testing and counseling

Care and treatment

- Treatment which has largely been left to MoHCW, Urban and rural council health facilities and mission hospitals.
- home-based care
- counselling (post-testing and bereavement)
- STD treatment

Relief support

- orphan support

Mitigation activities to ensure household expenditure patterns are maintained

- Income generation
- improving access of rural households to limited resources labour, land, capital, draft power, management skills (for example through draft power clubs, labour exchange clubs, money lending associations)
- optimal use of available resources through (a) improved technologies such as lighter ploughs, technology of animal weeding, easily threshed, or pounded crop varieties and (b) through promotion of existing labour and capital saving technologies that can be used

such zero or minimum tillage, intercropping, natural pest management,

- economic support to improve incomes of affected households through income generating activities (the aim is to maintain household expenditure patterns and promote savings)
- provision of self-support (empowerment) to affected groups like child headed households, widows, grandparents, youths, orphans, sex workers etc. aim is to reduce further vulnerability and strengthen their coping capacity
- Development of appropriate technologies to reduce the time spent on water and fuel
- Diversifying the income base of smallholder farmers by encouraging crop diversification and reducing external input requirements and encouraging other non-farm sources of income, particularly home-based income generating and petty trading activities after a sound analysis.
- Strengthening of existing community based initiatives such as strengthening customary ways of labour-sharing arrangements and introduce new methods as appropriate, strengthening traditional savings and mutual assistance associations.
- Micro-credit / micro-enterprises,/ employment creation schemes to empower communities specifically targeted to women and youths who perform most of the caring work. There is need to encourage self-sustenance of such schemes through training the participants and recycling of funds.

6.0. Social Safety Net

The Social Development Fund was established to provide a social safety net for those below a threshold income of Z$400, who could not afford food, school fees and health service fees. Administered under the Ministry of Public Service, Labor and Social Welfare, the SDF experienced major problems that have limited its success in helping the vulnerable groups cope with the impacts of macroeconomic reforms. Some of the problems cited in different literature include the following[10]:

- The application methods are complicated.
- The SDF budget is small, the Z$150 million allocated to it in 1993/94 was, in real terms one third smaller than the annual decline in government health and education spending, and the SDF budget has continued to shrink (Illif, 1995).
- The SDF was benefiting more urban dwellers than rural dwellers.
- The Z$400 income threshold is arbitrary, linked to the tax exemption threshold.
- SDF payments to the health institutions have been erratic and delayed worsening the problems faced by the health service institutions.

Recognizing the limitations of the social safety mechanisms, the government embarked on formulating a broad-based programme to tackle poverty in a more comprehensive and sustainable manner. Launched in 1994, by the MPSLSW and United Nations Development Programme (UNDP), the Poverty Alleviation Action Plan (PAAP) includes reform of SDF and more systematic and decentralized efforts to monitor and address poverty. The main thrust of PAAP include building the capacity of communities to generate income by targeting public expenditure to those areas with potential for highest benefit to the poor, decentralizing projects,

[10]Illif, 1995, Chisvo and Munro, 1994, Government of Zimbabwe, 1998.

and rationalizing social assistance. At the time of writing PAAP is still in its initial implementation phases, and there is not enough information to evaluate the program. However based on experiences of social emergency funds (short term relief oriented social compensation funds required during the crisis and adjustment period) and social investment programmes (funds required for longer term projects aimed at improving the efficiency and redistribution of social services to remove structural causes of poverty) in Latin America and the Caribbean the following points need to be considered if social assistance are to adequately meet the requirements of the health sector during macroeconomic reform periods[11]:

- The effectiveness of most social programmes could be improved by targeting specific needy populations poverty using maps. It is only through targeted relief that the equity objective can be achieved.
- There is need to clearly define the objectives and the indicators at the beginning of the project to ensure that evaluation of the impact of the programs on the health situation and the chronically poor or the new poor can be conducted.
- Social assistance funds need to be part of a comprehensive national social policy, well defined priorities and institutional coordination to ensure production of better designed projects that are sustainable.
- Short term strategies do not address the most crucial problems, there is need therefore for a combination of relief oriented and investment oriented strategies which ensures that when the funds are finished, the projects can be sustainable.
- The need to integrate HIV/AIDS prevention and mitigation programmes in the social assistance policy.

7.0. Lessons for the future

The major challenge facing macroeconomic policy makers as far as the health sector is deciding how to allocate the limited resources in the face of the AIDS epidemic in times of tightening of the national budgets as a result of macroeconomic reforms. This heightens the need for government to prioritise national programs across the different sectors and formulate macroeconomic policies and allocate resources based on the emerging priorities. The following issues however complicates government's priority setting process and resource allocation as far as the health sector is concerned:

- Multiple national objectives; efficiency, equity
- Health sector competing with other sectors for resources
- Within the health sector, AIDS competing with other health problems, what are the health priorities?
- Within the AIDS budget, expensive antiretroviral treatments competing with prevention and treatment of opportunistic infections.

National Priorities

Once the government has quantitatively set national priorities across all the sectors ensuring that multiple national objectives are optimised allocation of government funds across all sectors can be based on the identified priorities. This can be done by measuring the benefits (social and

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[11]Based on Campino, 1993, and Cornia et al, 1987.

economic) of investing in each of the sectors against the costs, both projected to the medium term planning period and discounted by the appropriate discount factors. Adoption of such a system of planning improves objectivity of decision-making while fostering consistency of resource allocation with the attainment of national objectives. The system is also transparent and ensures efficient allocation of resources. With such a system, health sector is likely to score high and allocation of funds to health is likely to increase. Why? Because

- investments in health have direct effects on productivity hence the whole economy
- of health's role in meeting equity objective
- if HIV/AIDS epidemic is not checked/prevented, the economy can be adversely affected

Health Priorities

Within the health sector itself, there is also need to prioritise all health programs to ensure that more cost-effective and efficient programs are prioritised. adopted through redistribution of resources from expensive hospital care to cost-effective primary care and district care. Primary health care programs such as investment in public health (immunizations, school based health services, family planning, AIDS prevention) and essential clinical services (pregnancy related care prenatal, child birth, postnatal, access to family planning, TB control, STD control, malaria, measles) as opposed to curative care which could be as much as 10 times the cost of treating the same patient at the primary level and is not accessible to many.

There is need to improve efficiency and effectiveness of existing health institutions through improved cost recovery and such institutions should have autonomy to utilise the funds raised from these programs.

HIV/AIDS Priorities

HIV is reversing the gains which had been accomplished in the health sector and if not checked the conditions can continue to deteriorate and might be difficult to recover. High level government commitment is required to plan and implement responses to fight the AIDS epidemic. AIDS is much more than a health issue, development of macroeconomic policies which take into account the fight against AIDS from sustainable development angle is required. Given the wide variety of inteventions available there is need for the government to prioritize limited resources across the different intervention programmes.

Cost recovery

The efficient allocation of a public good is achieved where **marginal benefit = marginal cost.** Therefore for health resources as for other economic goods, a mechanism should be established to recover appropriate costs for its provision equivalent to the full marginal social cost. If user fee collection is going to be a major source of income for health expenditures, then there is need to set the fees equal to the marginal cost of providing the service. For implementation, the current threshold figure of Z$400/month should be adjusted to reflect changes in inflation. The fees must be consistent, transparent, and publicised. However the actual application of such a mechanism to Zimbabwe is not easy because of the heterogeneity of the users some users have high and reliable income while some are poor with incomes below the poverty datum line and may lose from such a change. Yet efficient pricing of public goods should not make anyone worse-off. Thus the need for a targeted social assistance is heightened.

Targeted Social assistance for the vulnerable groups
The demand for welfare expenditure is likely to be increase because of the HIV/AIDS epidemic, and rising poverty as incomes are falling. What is important is to have the assistance well targeted so that needy populations are the ones who receive the assistance. This means decentralisation, reformed screening techniques, which PAAP is already trying to address.

Partnership with the private sector
As government resources are limited and might get scarce because of the heightened need for reducing the budget deficit and the interest burden, there is need to develop strong partneship with the private sector to promote diversity and competition. There need to strengthen private sector involvement in provision of medical aid and delivery of some clinical services particularly the corporate industry to their staff and families in the face of HIV/AIDS.

Staff retention in the medical field
Incentives matter if the health sector is going to retain professional staff in the sector.

Longe term strategy
The promotion of health depends fundamentally on improving socioeconomic conditions or elimination of poverty and underdevelopment thereby fostering an environment that enables households to improve health. Long term macroeconomic policies should be focussed at removing underlying factors (such as poverty, illiteracy, the rights and status of women, unemployment), if Zimbabwe's health is to be sustained, since health is a necessary and primary condition for development.

8.0. Conclusion

Macroeconomic policies are a major determinant of health sector performance. Health sector performance was outstanding in the 1980s following macroeconomic policies which were supportive of the health sector. However in the 1990s, with the introduction of ESAP, while the economy has made some progress in the other sectors of the economy, the social sectors particularly health has been under severe stress from the macroeconomic policies, AIDS and droughts. Health budget cuts, real decline in health worker wages, massive retrenchments, real increase in costs of drugs and imported equipment, real increases in food and other nonfood items, health cost recovery, increases in HIV/AIDS and increases all seem to have worked against the health sector resulting in its poor performance in the last seven years. Health outcomes such as nutrition, infant and child mortality, adult mortality, and maternal mortality have all exibited poor performance. What is needed is improvement in government resource allocations to health targeted by ZIMPREST, a modified cost recovery mechanism, intensified HIV/AIDS prevention and mitigation strategies and social assistance for the vulnerable, in order to rescue the health sector performance from the downward trend it seems to be taking.

Annex 1.

Health facilities in Zimbabwe by type of institution

Year	Central Hospital	General Hospital	Maternity hospital	District Hospital	Rural hosp	Private hospital, mine	Special Instn	Mission hosp&clinics	Govt clinics	Council clinics	Municipality clinics
1983	6	12	11	29	60	44	14	97		407	57
1985	4	12	6	28	56	173	10	46		424	55
1986	4	12	6	28	56	173	10	46		424	55
1987	4	12	6	28	56	168	9	45		334	55
1991	4	7		41	58	14	6	97			
1992	6	7	6	37	57	175	10	120	377	452	102
1993	6	7	3	37	58	204	11	126	370	451	105
1994	6	7	3	37	58	204	11	126	370	451	105
1995	6	7	3	37	58	204	11	126	370	451	105
1996	5	7	3	34	59	209	13	128	349	497	102

Source: CSO.

Annex 2
Performance of Key Health indicators

Table 9. The main demographic and Social indicators, Zimbabwe

Indicator	1978	1988	1994	1995
Life expectancy at birth (years)	57	61	62	57
Population million	7.539[3]			
Population growth rate	3.4[3]			
Rates per thousand				
Crude death rate	15[3]	8		9.6
Adult mortality rate			9.49[1]	
Maternal Mortality	130[3]	70[2]	170	
Infant mortality rate	83	52.7	49.6	
Under five mortality rate	103.6	75.1	74.8	83
Child malnutrition	30%	20%		
Immunization rate	25%[4]		80%	
Access to sanitation rural	100			98
Access to sanitation urban	5			50
Access to clean water rural	14		36%	65
Access to clean water urban	100			99
Access to health services	71	80		
Population per physician			46060	
Dependency ratio	102.9		94.4	

[1] 1992
[2]1990
[3]1982
[4]1980

Source: CSO, Quarterly Digest of Statistics (several issues), World Bank, African Development Indicators (1997), MoHCW (1995).

Annex 3

Health personnel resources (1983 and 1995)

	1983	1995
Population	7517000	9212000
Hospital Beds	10258	13673
Doctors	432	200
Nurses	5014	4245
Dental staff	31	47
Rehabilitation staff	50	165
Environmental staff	283	846
Laboratory staff	137	94
Pharmacy staff	66	92
X-ray staff	65	58
Population/ 1 Hospital Bed	732.79	673.74
Population/ 1 Doctor	17400.46	46060.00
Population/ 1 Nurse	1499.20	2170.08
Population/ 1Dental staff	242483.87	196000.00
Population/ 1 Rehabilitation staff	150340.00	55830.30
Population/ 1 Environmental staff	26561.84	10888.89
Population/ 1 Laboratory staff	54868.61	98000.00
Population/ 1 Pharmacy staff	113893.94	100130.43
Population/ 1 X-ray staff	115646.15	158827.59

Only public sector health services. Does not include personnel in private sector.
Source: MoHCW, 1995.

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